



Amanda R. Lloyd, MD

**Acknowledgement of Receipt of Notice of Privacy Practices**

I acknowledge that I was provided a copy of the Notice of Privacy Practices, dated 11/1/13, for Bright Steps Pediatrics.

\_\_\_\_\_  
Printed Name of Parent / Patient (if 18 yrs. and older)

\_\_\_\_\_  
Signature of Parent / Patient (if 18 yrs. and older)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

Please list name(s) of patient(s) and date(s) of birth:

Name \_\_\_\_\_  
Name \_\_\_\_\_  
Name \_\_\_\_\_  
Name \_\_\_\_\_

Date of Birth \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Date of Birth \_\_\_\_\_